Governor's Commission on Home and Community-Based Services
Recommendations for the Final Report

Task Force	Recommendations
Transitions Task Force	1. Adult day services should become a targeted service. 2. Raise the monthly income standard for the Medicaid Aged and Disabled Waiver to 300% SSI. 3. Add an adult foster care service option to the Medicaid Aged and Disabled Waiver. 4. Develop and implement a targeted Medicaid Waiver for adult foster care. 5. Develop and implement a Medicaid Waiver for persons with mental illness and support a number of complementary program initiatives. 6. Fully develop and implement the Medicaid Waiver for Assisted Living. 7. Modify the Medicaid Waiver approval process to expedite services and payment. 8. Streamline and reduce processing time for determining Medicaid waiver eligibility. 9. Establish a centralized Medicaid financial eligibility determination unit for Medicaid Waiver applicants. 10. Integrate state staff into the nursing home discharge process.
Transportation and Employment Task Force	1. Review and modify legislation that limits the service area of a Public Transportation Corporation to its taxing district. 2. Increase funding for public mass transit. 3. Develop employment standards for services provided to persons who have disabilities and/or have mental illness. 4. Implement a standard methodology for adjustment increases of the vocational rehabilitation rate. 5. Develop a Business Leadership Network.
Housing Task Force	1. The Governor should appoint a Housing Task Force. 2. RCAP funding should follow the consumer. 3. Legislation should be developed to implement a real estate transaction fee.
Children at Risk	1. Plan, develop, and implement an organized system of care concept for at-risk children. 2. The Governor should support the development of a prevention and early intervention strategy for children
CPASS	1. Develop a standardized, statewide rate ceiling for similar services provided. 2. Explore the option to provide benefits to increase the number of and retain personal care workers. 3. Develop the infrastructure for consumer-directed care.
Other	1. Medicare and Medicaid wheelchair and equipment coverage policy must be more responsive in meeting beneficiaries' health care and preventive care needs. 2. State eligibility policy for Medicaid and Social Security benefits should be modified to ensure that there is no lapse in coverage when a consumer transitions from an institution into the community. 3. Public funds should follow the client to the service setting of his/her choice. 4. The Indiana Family and Social Services Administration and other state agencies must pursue all grant opportunities made available through the President's New Freedom Initiative and all other grants that support Olmstead and the shift of the long-term care service delivery system. 5. Create a cross-disability consumer advisory council.

Problem: The U.S. Surgeon General has estimated that 20 % of the American population has some mental disorder in a given year, and about 5 % of the population is considered to have a serious mental illness (SMI). Based on these figures, an estimated 305,000 people in Indiana are expected to experience some form of mental illness each year, 68,000 of which are likely to qualify for publicly-funded services[1]. Currently, the Indiana Division of Mental Health and Addiction serves 41,000 persons in state hospitals and in the community mental health system.[2]

Mental health services provided in a community setting have proven to represent a much more cost-effective, desirable, and successful alternative to care provided in traditional institutional settings. Nevertheless, Indiana has never had available the funds necessary to develop a sufficient number of community service alternatives to meet the needs of its low-income, mentally ill and dually diagnosed (mentally ill/developmentally disabled) populations. Moreover, although some persons with mental illness have a serious disability that renders them eligible for Medicaid and nursing home care, many do not. As a result, they are not eligible for services funded by a Medicaid home and community-based services waiver. Although Indiana funds many services through the community mental health system and Medicaid (through the Medicaid Rehabilitation Option), there remain a number of persons who are served in state hospitals who could successfully and cost-effectively be served in an alternative community setting if one were available.

Recommendation 5: Implement a Medicaid Home and Community Based Services Waiver for persons with mental illness that includes people who are dually diagnosed (developmental disability and mental illness and/or mental illness and substance abuse) and support a number of complementary initiatives that are currently underway to further expand the community service alternatives for persons with mental illness.

Target Population. Those who would be affected by this change are certain low-income persons with mental illness and dual diagnosis (developmental disability and mental illness and/or mental illness and substance abuse) and who meet institutional eligibility criteria (i.e. state operated facilities, nursing homes, or intermediate care facilities for the mentally retarded).

Policy Outcomes. The development and implementation of a new Medicaid Home and Community Based Services Waiver for Persons with Mental Illness will bolster the community-based service options already provided in Indiana and will help to prevent unnecessary institutionalization. More persons with mental illness can be served through the Medicaid Waiver and at less cost than in the equivalent institutional setting. Successful and consistent community treatment outcomes will positively influence overall health care costs, and the consumer's health, level of independence, employment retention, and quality of life. Institutional resident census may be decreased, and overall state institutional costs may be reduced.

System Barriers. The system barriers include: lack of information about how to access programs and funds among providers, consumers, and families; lack of affordable and accessible housing; lack of funding for supported employment and supportive housing; lack of available jobs and

[1] U.S. Department of Health and Human Services. (1999). Mental Health: A Report of the Surgeon General. Rockville, Maryland.

[2] Report from the Indiana Division of Mental Health and Addiction, 2002.

transportation; and lack of adequate personal care services provided in the individual's or family's home. Other barriers include: lack of adequate state staff to develop, implement and monitor the new waiver program; computer system changes that may be complex, costly and time-consuming; and lack of funding. Without additional resources, the Indiana Family and Social Services Administration may not have the staffing or expertise in development and oversight of an additional Medicaid Waiver Program, which by definition, carries with it separate administrative and federal reporting responsibilities.

There are also a number of barriers related to Medicaid coverage of persons with mental illness. Federal regulations specify that federal financial participation is only available in institutions for mental diseases (defined as institutions with more than 16 beds[3]) for individuals less than 21 years and 65 years or older. This creates a gap in funding for adults between the ages of 22 years and 65 years (See 42 CFR 441.11). Since, Medicaid home and community-based services waivers are specifically defined as a service option to be used in lieu of institutional care, Medicaid funding that is not available for certain populations (like persons with mental illness) in an institution can not be made available through a Medicaid waiver. Furthermore, in applying for a Medicaid waiver, the State needs to demonstrate cost-effectiveness by comparing costs for the population to be covered in the waiver to the costs of their care in an institution. Therefore, if Medicaid does not cover the costs of institutionalization, there is no cost comparison for the provision of services in the community.

It is also important to consider Medicaid eligibility in general. Individuals covered through the Medicaid program are (in broad categories), low-income families receiving cash assistance (TANF), pregnant women, children, and Aged, Blind and Disabled populations. Therefore, persons with mental illness who do not meet any of the Medicaid categorical eligibility criteria, would not be Medicaid-eligible and would also then not be eligible for a Medicaid waiver program.

Responsible Agency(ies) and Action Steps. The Indiana Division of Mental Health and Addictions, the Division of Disability, Aging and Rehabilitative Services, and the Office of Medicaid Policy and Planning within the Indiana Family and Social Services Administration are responsible for developing and implementing the new Medicaid Waiver for Persons with Mental Illness. The action steps include:

- Evaluation of what services can be made available to address the needs of persons with mental illness and then determine what funding options can be available.
- Evaluation of Medicaid home and community-based services waivers and other Medicaid waivers for persons with mental illness already implemented in other states to determine the best model for Indiana to pursue. Currently, such waivers exist in the states of Colorado, Washington, California, Michigan, Utah, Texas, and Florida. Some of these waivers are 1915 (traditional model) and others are 1115 (demonstration).
- Completion of a comprehensive fiscal impact analysis by population targeted and the model to be implemented based on research of the above action step. (This waiver will have very different costs depending on the needs of the population; i.e. whether they are dually diagnosed with mental illness/developmental disabilities or mental illness/substance abuse).
- Completion of a fully-developed implementation plan, including development of appropriate Memoranda of Understanding between responsible state agencies for the new Medicaid Waiver, if appropriate.

[3] 42 CFR 435.1009

- Depending upon the research performed above, the Medicaid Waiver should include services such as adult day care, alternative care facilities, electronic monitoring, home modifications, non-medical transportation, respite care, personal care, hearing-impaired services**,** and homemaker services.
- Submit the Medicaid Waiver application to the Centers for Medicare and Medicaid Services for review and approval.
- Determine whether rules will need to be promulgated.
- Promulgate rules as applicable.
- Ensure adequate quality assurance by investigating independent case management services for persons with serious mental illness.
- Secure State Medicaid Match required to support a waiver initiative for both waiver costs and medical (non-waiver) costs.
- Establish and monitor outcome measurements to quantify cost savings, as completed in other states with waivers for persons with mental illness.

Complementary initiatives that should be pursued are as follows:

1. The Division of Mental Health and Addiction should be encouraged to continue its development of a Medicaid Home and Community Based Services Waiver for Children with Serious Emotional Disturbance, which will target 50 – 200 youth in the community who are or would otherwise be served in a state mental hospital.
2. The Indiana Medicaid Rehabilitation Option should be modified to include supported employment as a covered service. This policy change will assist in ensuring that people with serious mental illness are better supported in retaining community employment.
3. Vocational Rehabilitation Services should work in providing better information about supported employment, which are funded with non- Medicaid dollars and are currently underutilized.
4. The Indiana Family and Social Services Administration should research the educational benefits of the Texas Medication Algorithm, which provides an option to generic drug substitution, as well as, evidence-based practices for adults and children with mental illness and dual diagnosis. Information should be disseminated statewide.

Fiscal Impact. Since this is a new Medicaid Waiver Program, new funding will be needed for the initial implementation. The fiscal impact will be based on service utilization, and the design, development, administration, and oversight of the program. The cost could be considerably mitigated if state funds that are currently supporting other, related services, such as institutional care, were shifted to this program.

In the longer term, as the waiver program grows, there can be expected a cost savings that results from a significantly-decreased rate of institutionalization for these populations, as well as a decreased length of stay.

Targeted Completion Date. The Indiana Family and Social Services Administration should develop a comprehensive fiscal impact analysis that consists of the following:

- The number of consumers to be served by the program, for each of the first two years;
- Detailed administrative costs related to program design and development (i.e. computer system; staffing; other);
- Expected service costs (both waiver and medical services costs), including estimated provider rates, specialized case management, and direct state staff involvement; and

- Detailed administrative costs related to quality oversight and monitoring, including at minimum: state staff; case management; long-term care ombudsman; program auditors; and adult protective services.
- The long-term effects of the shift from institutional care to community-based services; i.e. the estimated decrease in, and timing of, state hospital expenditures; when and by how much overall cost savings will occur.

Researching the desired model to be implemented in Indiana should be completed by October 1, 2003. The associated fiscal impact analysis should be completed by no later than November 1, 2003 and be presented at the final Commission meeting in December 2003. It should be accompanied by a comprehensive implementation plan, also due on November 1, 2003.

Finally, a new Medicaid Waiver for Persons with Mental Illness should be implemented as soon as possible but only after all funding has been identified and all action steps have been completed.

Problem: Medicaid Home and Community-Based Services Waiver providers are not authorized to begin delivering services until a number of administrative steps have been completed. This administrative process is unnecessarily time-consuming and complicated, resulting in a significant delay between when Medicaid-eligible consumers are determined to be eligible for the waiver and the date that case managers are notified electronically that services may be initiated. The delay is often so great that some waiver providers are no longer available to serve the consumer when the waiver approval is finally received, or they decline to accept new waiver clients altogether. As a result, consumers may no longer be able to wait to receive the necessary care in the community, so they are unnecessarily institutionalized because nursing home services can be approved much quicker.

Recommendation 7: The Medicaid Waiver approval process should be modified to allow the cost comparison budget that is developed locally and early on in the approval process to serve as the initial waiver plan of care. This approach is the same as that used in determining institutional eligibility and will reduce the time involved in the waiver approval process significantly. In addition, it will allow waiver providers to initiate and be paid for services much earlier (at the time that the cost comparison is developed). This approach has already been implemented successfully for the preadmission screening process with an error rate of less than 1% out of 4,000 decisions made locally4.

Target Population. Those who would be affected by this change are persons who are frail and elderly and/or disabled, and who meet institutional eligibility criteria, including: adults age 65 and over; and physically and/or developmentally disabled individuals of any age.

Policy Outcomes. The implementation of this recommendation will allow Medicaid Waiver services to be initiated more quickly, thereby allowing more consumers to receive necessary care in the community setting of their choice with more providers willing to provide that care. It will help to eliminate institutional bias by allowing services to be arranged for and provided more quickly to consumers. Similarly, it will also assist in building the waiver provider base by allowing services to be provided soon after the service plan is developed and by assuring more timely reimbursement.

System Barriers. There may be administrative or process obstacles involved with modification of the existing process and unwillingness by state staff to view the cost comparison that is developed locally as the initial plan of care and the trigger for reimbursement. Historically, state staff have made an overly restrictive interpretation of a federal limitation that reimbursement can not be initiated prior to the approval of the initial plan of care.

Responsible Agency(ies) and Action Steps. The Office of Medicaid Policy and Planning and the Division of Disability, Aging and Rehabilitation Services within the Indiana Family and Social Services Administration are responsible for pursuing and implementing this change. The action steps include: developing the written policy; modifying any necessary intake forms, modifying computer systems, training state staff about the process changes, developing informational outreach for consumers and providers, and requesting approval for the policy change to the Centers for Medicare and Medicaid Services in the form of a written Medicaid amendment to the Aged and Disabled Waiver.

[4] ***Source?***

Fiscal Impact. There is no administrative expense associated with this change. There may, however, be some administrative savings associated with increased efficiency in processing; i.e. fewer action steps for obtaining approval.

Targeted Completion Date. This policy change should be implemented by no later than July 1, 2003.

Problem: The Medicaid Home and Community Based Services Waiver Program application and approval process is very complicated and time-consuming. Consumers throughout Indiana who apply for Medicaid and the Medicaid Waiver Program often must wait months for their eligibility to be determined and approval of the individual care plan and budget. Since Medicaid Waiver services cannot be provided until that approval is received (this includes approval of plan of care/cost comparison budget as well as Medicaid financial eligibility and level of care), consumers may experience deterioration in their condition and/or be institutionalized because they can no longer wait for the needed assistance.

Recommendation 8: The Indiana Family and Social Services Administration should immediately evaluate and implement administrative process changes that will streamline and significantly reduce the time involved in determining Medicaid Waiver Program eligibility (focusing on development and approval of the individual plan of care/cost comparison budget and the level of care entry) and initiating services. The Agency should also implement a pilot program that will transfer the plan of care/cost comparison approval process to a local administrative unit[5] and thereby further reduce processing time. This pilot should be carefully designed, monitored, and evaluated to determine whether state-wide implementation is desirable and feasible. It shall include: local approval of the individual care plan and budget; and local monitoring and quality assurance of waiver providers. (Please note that this recommendation does not intend for local monitoring and quality assurance to replace the federally-required quality, fiscal and other oversight for which the Indiana Family and Social Services Administration is responsible.)

Target Population. Those who would be affected by this change are persons who are frail and elderly and/or disabled, and who meet nursing home eligibility criteria, including: adults age 65 and over; physically disabled individuals of any age; and persons with developmental disabilities who have overriding medical needs.

Policy Outcomes. Implementation of this recommendation should reduce by at least 50% the time it takes to complete the waiver approval process and allow consumers to access needed services. Examples of possible opportunities for improvement include: paperwork that is transferred multiple times between the same process points; the requirement of up-front, written doctor approvals which are necessary but extremely time-consuming to obtain; and collection of detail on the cost comparison budget that is very difficult and time-consuming to develop.

With respect to the pilot program, clear outcome measures should be determined prior to the start of the pilot program. The pilot model needs to be established so that if it is successful, it can be replicated in a consistent manner across the State**.**

System Barriers. Administrative system barriers may include Medicaid and other computer system changes, and approval by the Centers for Medicare and Medicaid Services (CMS). At this time, the Office of Medicaid Policy and Planning does not support expansion of the pilot to authorize the local administrative unit to manage the waiver payment process for several reasons,

[5] Local Administrative Unit (LAU) is defined as the entity with the contract responsibility to administer the Medicaid Waiver Program locally and which has the ability to meet written defined expectations.

including but not limited to: lack of consistency in rate structures or how rates are determined locally and widely varying rates for Medicaid waiver services and rates paid locally for similar services under Indiana's CHOICE program. These differences must be evaluated and resolved prior to any consideration of feasibility for a local administrative unit pilot of rate payment for waiver services.

Responsible Agencies and Action Steps. The Office of Medicaid Policy and Planning and the Division of Disability, Aging and Rehabilitation Services within the Indiana Family and Social Services Administration are responsible for pursuing and implementing this pilot. Action steps include:

- Evaluating the Medicaid Waiver approval process and identifying opportunities for efficiency
- If necessary, reviewing best practices of other states that have short application and approval processes
- Training state staff and contractors on the process changes that will be made
- Designing necessary computer system changes
- Implementing all changes consistently and effectively
- Establishing a comprehensive monitoring tool that will allow state staff to identify the effects and overall success of the process modifications, and make any necessary adjustments quickly
- Automation of level of care data entry process (between InSite and IndianaAIM); this has already been initiated.

For the pilot program:

- Identification of two local administrative units, one urban and one rural;
- Development of standards to measure the capacity of local agencies to administer the Medicaid Waiver Program locally;
- Evaluation of the accuracy of the software called InSite;
- Evaluation of the differences between the Medicaid Aged and Disabled Waiver and the CHOICE Program (e.g. why do care plans from clients moved from the CHOICE Program to the Medicaid Waiver increase;
- Evaluation of when it is not cost-effective to transfer a client from the CHOICE Program to the Medicaid Waiver); and
- Development of a policy structure for local administrative units that will assure coordination with other agencies, such as the Bureau of Developmental Disabilities Services and independent case managers.
- Development of an outcomes measurement tool to evaluate the progress of the pilot to quantify any positive change and to assist in determining process improvements and state-wide applicability.

Fiscal Impact. The fiscal impact will consist of any computer and other administrative system changes associated with streamlining the approval process, and monitoring the pilot program.

Targeted Completion Date. Processing time for the Medicaid Waiver approval process should be modified and significantly reduced (by at least 50%) by no later than January 1, 2004. The pilot program should be designed and implemented by July 1, 2004.

Problem: The Medicaid Home and Community-Based Services Waiver application and approval process is very complicated and time-consuming. By necessity, it includes two separate determinations: one for general Medicaid Program eligibility (which includes financial and, in some cases medical disability determination) with shared responsibility between the county office of Family and Children and the Office of Medicaid Policy and Planning; and the other for determining Medicaid Waiver Program eligibility (which includes level of care and plan of care/cost comparison budget), the responsibility of which is shared between the local area agency on aging, the Office of Medicaid Policy and Planning, and the Division of Disability, Aging and Rehabilitative Services. Although there are no time requirements for determining Medicaid Waiver Program eligibility, federal regulation requires general Medicaid Program eligibility for individuals applying for Medicaid disability to be determined within 90 days from the date of the individual's application for Medicaid, and for other populations to be determined within 45 days from the date of application6. For many reasons, determining Medicaid eligibility more quickly is difficult to achieve.

Recommendation 9: The Indiana Family and Social Services Administration should establish a centralized Medicaid financial eligibility determination unit that is dedicated to Medicaid Waiver Program applicants. The purpose of this administrative change is to expedite the approval process for Medicaid Waiver applicants so that undesired institutionalizations may be avoided, and consumers are given the opportunity to receive services in their own homes and/or other community setting and to age in place for as long as possible.

Target Population. Those who would be affected by this change are all persons who apply for Medicaid Home and Community-Based Services Waiver Programs.

Policy Outcomes. Implementation of this change will create administrative efficiencies in processing time, training, and information sharing. Those administrative efficiencies are expected to create more timely determinations of Medicaid program eligibility, thereby allowing necessary services to be provided more quickly. This change will reduce the likelihood that consumers who prefer home care will need to be institutionalized unnecessarily. Improvements in the administrative process can also be expected to positively impact Medicaid Waiver providers by reducing the time between when services are arranged and when they can be initiated (and paid).

System Barriers. There are a number of administrative process and computer system changes that are required. State resources may be limited, as well as dedicated space to house the centralized staff and function.

Responsible Agency(ies) and Action Steps. The Division of Family and Children and the Office of Medicaid Policy and Planning within the Indiana Family and Social Services Administration are responsible for implementing this change.

Action steps include:

- The Division of Family and Children must request approval of necessary staff by the Human Resources Division and State Personnel (Done).

[6] 42 CFR 435.911(a).

- The Division of Family and Children must recruit, hire and train staff (It may be necessary for staff to be phased-in over a period of time.).
- The Division of Family and Children and the Office of Medicaid Policy and Planning must identify space in the Central Office for staff.

Fiscal Impact. A fiscal impact analysis has already been completed by the Division of Family and Children as part of the request for approval.

Targeted Completion Date. Implementation should be phased in beginning July 1, 2003.

Problem: The Indiana Medicaid Program's nursing home budget (approximately $900 million annually) continues to be significantly higher than other states and approximately ____% higher than Indiana's Medicaid Home and Community-Based Services Waiver Program budget (approximately ___ annually). In order to balance long-term care expenditures to better accommodate consumer choice in care and service delivery, Indiana must implement a diversion process that presents consumers with real alternatives to nursing home placement and/or supports them during a short stay in the nursing home for rehabilitation.

Indiana has been working toward this goal for a year. Even though there is progress, as of May 1, out of a goal of 1,000, there have been only ___ persons who have been successfully diverted. This slow progress can be attributed to a number of administrative and other barriers that include the following:

1.) Hospital discharge planners and social service designees are responsible for efficiently and expeditiously discharging hospital patients. They are familiar with nursing home level of care criteria and are generally able to transfer patients who are nursing home-eligible quickly and safely; they are not paid or assigned the responsibility to pursue the State's goal of diverting consumers from institutional care and doing an at-home evaluation or performing a case conference with the family.

2.) Nursing home social service designees face similar barriers – lack of training, lack of priority by management and demands to keep beds filled.

Recommendation 10: State and/or contractor staff must be integrated into the nursing home discharge process to ensure that consumers who can remain in their own homes/community setting can receive necessary services and/or support and monitor consumers who are placed in nursing homes for temporary care to ensure that they are successfully transitioned back into their own home or alternative community setting of their choice.

Target Population. Those persons who will be affected by this change are all acute care hospital patients who are in the process of being discharged and who meeting nursing home level of care criteria.

Policy Outcomes. Implementation of this change will allow consumers the opportunity to understand their care choices, make informed choices, and receive on-going case management to support and monitor the care received. Undesirable institutionalization may be averted, thereby improving the consumer's opportunity to age in place in the setting of his/her choice, and improving quality of life. Additional acute care episodes may be minimized and undesired institutionalization delayed or avoided altogether.

System Barriers. The barriers to implementing this recommendations are as follows:

- If the state discontinues funding the regular Medicaid Aged and Disabled Waiver Program slots, there will be even fewer community service alternatives available for consumers who wish to avoid nursing home placement.

- The present system does not distinguish between an individual placed in a nursing home for rehabilitative services and one who needs rehabilitative services and then assistance in returning home. Without a case manager follow-up within the 100 days of nursing home care covered by the federal Medicare Program these individuals tend to remain in the nursing home indefinitely.
- There is an insufficient number of case managers available to follow the consumer to nursing home and facilitate transition back to the home or other community setting.
- Hospital discharge planning staff may not be able to assist with the additional responsibilities associated with a diversion initiative unless there is a financial incentive and/or legislation/rule/mandate that requires their participation.
- Individuals working within institutional settings (like acute care hospitals and nursing homes) may be uninformed about available community care service options and about the very different quality standards that apply to non-institutional settings.
- Legislation, rules and/or mandates may prevent necessary access of the area agency on aging diversion staff to information related to the hospital discharge.

Responsible Agency(ies) and Action Steps. The Office of Medicaid Policy and Planning and the Division of Disability, Aging and Rehabilitative Services within the Indiana Family and Social Services Administration are responsible for implementing this change.

Action steps include:

- Evaluation of successful program models used in other states (e.g. Illinois and Washington). The model should include: universal pre-screening and funding for case managers employed by the State to follow the consumer into the nursing facility.
- Completion of a fiscal impact analysis to determine the full administrative cost of implementing this diversion process.
- Development of policies, rules, and/or legislation needed to implement this recommendation.
- Development of simple, clear and concise education and marketing tools, the target of whom will be hospital discharge planners, doctors and nursing facilities.
- Define the process as a Universal Screening Process that encompasses nursing home placement, home and community based services (CHOICE, Medicaid and private pay), and/or the opportunity to refuse all services.

  The Universal Screening Process shall:
  - ✓ Educate individuals at risk of nursing facility placement[7] and their families/caregivers about options for long term care.
  - ✓ Result in an improved quality of life and care for individuals by giving them the choice to receive care based on a person-centered plan.
  - ✓ Reduce inappropriate nursing facility placement.

  The process must include maximum of time to complete each step. For example, Illinois' time frames are:

[7] "At risk" is typically defined as someone who experiences three hospitalizations and/or inpatient nursing home/rehab services within a 12 month period.

- Universal Prescreening – within 2 calendar days of referrals (date of referral is not counted as a day); perform this with a caregiver/family conference whenever possible.
- Case management follow-ups – in place within 2 working days from the date of notification.
- Follow-up visit by the case manager after nursing facility placement – within 60 calendar days of placement.
- Post screening – completed within 15 calendar days of request.

Fiscal Impact. A fiscal impact analysis will need to be completed that includes adequate funds for staff and administrative functions such as marketing and educational funds. A possible standard may be 1 FTE (full time equivalent) for every 60 attempted and 20 successful diversions.

Targeted Completion Date. A comprehensive fiscal impact analysis should be completed by September 30, 2003. This analysis should be accompanied by an implementation that includes potential funding source and a full phase-in plan. Rules should be pursued as soon as funds are identified; or if legislation is required, it should be pursued during the 2004 legislative session. This recommendation should be implemented beginning on July 1, 2004.

Problem: Currently, fewer than 20% of Indiana children who are at risk of long-term, out-of-home placement are served by an organized and unified system of care. This creates an inconsistency in how children's needs are addressed by professionals within the various service systems in which children and their families are involved. Often children are involved in two or more of these public service systems, and children and their families experience complex, overlapping and even contradictory "treatment plans" that are physically, mentally and emotionally exhausting. In addition, the services provided to the child and family often do not meet their needs, are unnecessarily costly, and result in less than desirable, long-term outcomes.

Recommendation 1: The Family and Social Services Administration should assist each Indiana community to implement an integrated and unified system of care that is organized to respond to the needs of children who are at-risk of long term out of home placement.

A system of care is a "comprehensive spectrum of services and supports that are organized into a coordinated network to meet the multiple and changing needs of individuals and their families". The infrastructure would be designed in each community, but the core values and principles of a system of care that serve as the foundation of the network and service delivery would be consistent statewide. The system of care should be child and family focused, community based and culturally competent. Individualized care that matches the needs of the child and the family with services and supports would be provided in the least restrictive setting through a comprehensive array of services. Integrated across child service systems, services would include case management and care coordination, early identification and timely transitions to eliminate a break in services. Current individual systems of services must be coordinated and organized to promote this system of care concept. Whereas an overall policy direction and the expected outcomes for children and families served by the system of care should be established at the state level, the development and implementation of the system of care must be accomplished by and through the leadership and strengths of each local Indiana community. Services provided within the framework of an organized system of care must be based upon the specific strengths of the family and the child who is at-risk of out-of-home placement.

Target Population: Those who would be affected by this change are children and their families who may be "at-risk", "at imminent risk" or "in risk" status as illustrated in the attached diagram and definition of terms.

Policy Outcomes: A unified system of care is a common-sense approach to children's services that promotes the healthy development of a child's physical, mental, emotional, behavioral and academic development. It suggests a new way of thinking about services and, when designed properly, consists of a comprehensive array of services that is organized into a coordinated network to meet the needs of children and their families. One of the unique hallmarks of the presence of a system of care is an integrated and single cross-agency service plan for each child and family. It includes a menu of home and community based services, residential placement, and respite care and involves formal and informal supports and services that are chosen by the family, not simply through input, but by deliberate and informed decision-making. It is an approach that is child-centered, family-focused, community-based, and culturally competent with all services individualized in the least restrictive environment. A system of care is not a process, a model or a program. It is a framework that can be used by individual communities based upon that community's special needs, resources, collaborations and existing service delivery systems to develop a full array of services to meet the needs of children and their families. The replication or

transfer of a system of care from one community to another is impractical as a system of care must be developed within a consistent conceptual framework but specifically tailored to the unique qualities and strengths of individual communities. Information and education about the specific meaning of a system of care must be offered by the Family and Social Services Administration in conjunction with other state agency partners, and must precede local implementation

In addition to the outcomes described above, services provided within the scope of a system of care will:

- Decrease the number of costly long-term, out-of-home placements;
- Decrease the length of time a child is in out-of-home placements;
- Allow funds to be used more efficiently; and,
- Re-direct funds more toward prevention and early intervention services without endangering funding for current services and interventions.

System Barrier: Emphasizing the strengths of each Indiana community as well as the various existing service systems and organizing them into a meaningful array of services based upon the principles of a system of care can be the basis for overcoming any impending system barriers. Implementation of this recommendation will require the establishment of a partnership between the Indiana Family and Social Services Administration and a number of state agencies and entities, community leaders, and children's service providers. Strong leadership and commitment will be required to balance the interests of all parties, design a viable and fully-functional system of care and establish and implement a successful and fully-accountable evidence-based system approach. Changes in computer resources will be necessary, and multiple funding streams will need to be evaluated and carefully selected and utilized to maximize federal reimbursements. State staff may have difficulty in promoting and accepting change. The affected population will have to be closely monitored to assure that they are not adversely impacted during periods of transition and system change. Educational and training protocols will need to be developed and implemented for all stakeholders.

Responsible Agency(ies) and Action Steps. The Indiana Family and Social Services Administration will take the lead on this initiative. Other primary stakeholders will include: the Indiana Department of Education; the Indiana Department of Health; the Indiana Judicial Conference; the Indiana Judicial Center; the Indiana Department of Correction; the Criminal Justice Institute; community leaders; and children's service providers. The state partners must model, promote and enhance the coordinated approach expected of local collaborative efforts in order to meet the outcomes expected for children and families served by a system of care. It is imperative that an organized system of care is understood consistently through a clear communication of statewide policy and uniform training, is developed locally with a common shared vision, and that continuous quality improvement and evaluation is based upon impartial research. Existing appropriations must be fully maintained and the provision of services to "in-risk" and "at imminent risk" children must not be jeopardized, reduced, transferred or re-directed to pay for new systems development for earlier intervention or prevention services.

The policy direction for the development and implementation of an organized system of care must originate as a state priority initiated by the Governor. His vision must be communicated clearly throughout state government and local communities so that the Governor's policy is consistently understood but implementation of the policy is managed locally within the framework of the policy by local juvenile justice, child development, academic, mental health and child welfare professionals in collaboration with families. The Governor also should establish a

committee of appropriate agency heads to implement and be accountable for the system of care concept and to resolve inter-agency policy conflicts that will be identified as the system of care is implemented. The committee of agency heads should be responsible to provide statewide input into national strategies and discussions on systems of care, resolve emerging system development issues, provide promising practice information, offer technical assistance to local communities and provide the forum to determine what components of implementation should be consistent or standardized statewide and which should be left to the discretion of the local community. The inter-agency effort should have dedicated staff support to ensure effective policy analysis, data collection and processing of policy changes and interpretations.

Other action steps for which the Family and Social Services Administration will be responsible are as follows:

- A plan must be developed that identifies timelines, necessary actions, and responsible agencies for statewide implementation of the system of care concept;
- Memoranda of Agreement must be developed and implemented by state and local agencies that identify specific roles in the development, implementation and management of the system of care;
- Training must be developed that consistently communicates the definition and philosophy for a system of care and the implementation strategy for Indiana's system of care vision, both for families who are involved in public systems and for the workers providing and managing the services in the system. Training must help families understand the system of care concept so they are confident in the understanding of the concept and thereby building trust among the families, the service providers and the agencies involved in the system of care;
- System-of-care training must endorse and promote cross-training among appropriate agencies, including child welfare, juvenile justice, mental health, child development and schools;
- Development of fiscal policy that provides an incentive to courts, probation departments, child protective services, child development providers, educational professionals and service providers to maximize appropriate home-based and community services when appropriate and encourages the advancement of prevention and early intervention services, as well as continuous quality management;
- Development of consistent and coordinated needs and service assessments in the juvenile justice, child protective and educational systems that assess a child's safety, assess how well services are matched with the child's and family's needs that set the framework for a single coordinated plan that reduces the need or likelihood of long-term, out-of-home placement. Assessment practices avoid repeated interviews and surveys that yield limited additional information.
- Application for and full implementation of waivers from the federal government must be pursued, implemented, and fully utilized, including the waivers for the IV-E program, the home and community based services waiver and the Medicaid Rehabilitation Option (to eventually include not only partnerships with licensed child placement agencies, but also independent providers);
- Administrative funds and reimbursements through the IV-E program and other federal programs must be maximized to provide the cash flow needed to bring about these systemic changes without increasing program budgets as current systems of services are developed into an organized and unified system of care;
- Enhancement of automated information systems that serve children in the various service systems must be enhanced to provide better coordination of information and more efficient management of services for children in two or more of the systems;

- Consistent implementation of service, case management and eligibility definitions as well as policies concerning the management of information across state and local agencies;
- Collaboration and cooperation among the agency's three service divisions and with other state agencies that provide services to children including quality assurance reviews in the delivery and management of the services based upon recognized performance standards;
- Development and implementation of an automated accounting system that provides the controls and accountability expected by taxpayers for the expenditure of public funds and that provides a platform for state and local agencies to "pool", "braid" or "blend" local, state and federal dollars, even those not commonly known or used, to maximize cost effectiveness;
- Codification of "best practices" that are available on a website and on-going communication and training processes must be established to provide technical assistance to communities as these organized systems of care are developed;
- Prioritization of evidence-based "best practice" standards so: 1) funds are not removed from other under-funded services; 2) dollars saved through efficiency and better management of services are re-directed to other needed child and family services; and, 3) some administrative savings are realized and used for third party evaluation of the new system to avoid unintended consequences;
- Development of Medicaid funding streams that can enhance appropriate services in schools, local health departments and health facilities;
- Promotion of community capacity in all areas of the state, specifically in the more rural areas that currently may have gaps in the full continuum of children's services.
- Expansion of university and internship programs for psychologists, social workers, educators and other service professionals in conjunction with institutions of higher education and the system of care philosophy should be included in the educational curricula of these professionals;
- Identification of expanded outcomes for the successful implementation of the system of care must be monitored and tracked on an on-going basis in an effort to identify appropriate agency and staff competencies and to serve as the impetus for continuous quality improvement. This will allow Indiana to measure its progress toward a fully integrated system of care;
- Evaluate outcome data against baseline data that is collected for June 30, 2003; and,
- Legislate and implement workload standards that provide adequate time for workers in mental health, child welfare, juvenile justice, schools and developmental disability areas to work with children and their families.

Fiscal Impact: It is anticipated that the cost of this systems change can be managed within existing state and local budgets, provided: a) federal program and administrative reimbursements and waiver approvals are maximized, b) thoughtful and deliberate efforts are managed to re-direct appropriate "high cost" out-of-home placements into safe and meaningful community and home based alternatives so as to create necessary cash flow, and c) duplication of efforts in eligibility determination and other administrative inefficiencies are eliminated.

Targeted Completion Date: Every child at-risk of a long-term out-of-home placement will be served by an organized system of care by June 30, 2007.

DEFINING THE AT-RISK CHILD

I. Pregnant Mothers (Prenatal) At-Risk Indicators
1) Tobacco use
2) Alcohol and drug use
3) Lack of healthcare visits in the first trimester
4) Nutrition/diet quality/food insecurity
5) Pregnancies too close together
6) Un-married teen pregnancy
7) Low Birth Weight
8) Housing stability
9) Employment stability

II. Child Well Being Outcomes
1) Living in financial security
2) Housing stability and security
3) Continuous healthcare
4) Nutrition quality/food security
5) Current immunizations
6) Regular well baby visits
7) A family which reads to the child
8) Affordable and quality childcare
9) Support from extended family or friends

III. Children Who May Be At-Risk:
1) TANF recipients
2) Food stamp recipients
3) Free and reduced school breakfast and lunch recipients
4) Baby born to a mother under 20 with no high school diploma
5) Sibling arrest
6) Sibling who is a victim of abuse or neglect
7) Stressfulness in the social environment
8) Parent-child separation
9) Lack of parent and child bonding
10) Family economic stress
11) Loss of insurance, insurance that does not cover a specific condition or insurance with high co-pays
12) Lack of access to healthcare
13) Criminal arrest in family
14) Parent incarcerated
15) Neighborhood disorganization (crime, gangs and drugs)
16) Parental abuse of drugs and alcohol
17) Children of parents with serious mental illness or developmental disabilities
18) Children with autism or serious emotional disorder

IV. Children At Imminent Risk:
1) Victim of abuse, neglect or other crime
2) Truancy and academic failure
3) Delinquent act
4) Child use of drugs or alcohol
5) Probation or parole violation

6) Children aging out of the foster care system

V. Children In-Risk:
1) Children in state operated facilities
2) Commitment to the Department of Correction
3) Children in-patients in private hospitals with private pay
4) Children in private detention and treatment centers
5) Parole Violators

VI. Organizational At-Risk Indicators:
1) Lack of appropriate workload standards
2) Absence of or inadequate staff orientation and training
3) Lack of child and family needs assessment
4) Lack of needed agreements among service providers
5) Inadequate public education and information and outreach
6) Inadequate funding to support service needs
7) Lack of clear agency policy and guidelines
8) Un-timely approval of provider certification or licensure
9) Inadequate provider reimbursement rates
10) Cumbersome process to receive provider payments
11) Insufficient cash flow to manage the agency
12) Un-timely payments to providers
13) Absence of a quality assurance process
14) Inadequate staff supervision
15) Low staff retention
16) Inadequate information system
17) Untimely eligibility determination
18) Inadequate or unresponsive appeal process
19) Inappropriate case management review process
20) Non-compliance with federal and state program requirements, including inadequate record-keeping and adherence to financial criteria resulting in loss of funds
21) Lack of effective local interagency coordination
22) Lack of a person centered and family centered decision-making process

"The number of risk factors is more predictive of "at-risk" results than any one factor by itself or any combination of several.

Problem: Most Hoosier children are born healthy and experience physical, mental, emotional, developmental and academic outcomes, free from abuse, neglect or involvement in the juvenile justice system. Hoosier children who do not experience these outcomes often enter a public system of services and may fail to reach their full potential. The number of children who could experience these well-being outcomes can be increased through the promotion of first trimester healthcare, on-going prenatal care, and needed support provided by healthcare and other service professionals. While the importance of these services is well documented, budgetary constraints often limit scarce resources to be directed to older children who are involved in more intense or traumatic situations. This focus on the older child creates an on-going need for more costly services, because prevention or early intervention services were not available. Research indicates that the later the intervention, the greater the likelihood that the intervention will be less effective, and more costly.

Recommendation 2: The Governor must issue a clear statement that identifies an on-going commitment by the State of Indiana to early identification and assessment of children who need services as well as a comprehensive prevention and early intervention strategy for Hoosier children. The Family and Social Services Administration should develop and implement a strategy to maximize the benefits available through the EPSDT component of Medicaid, and utilize the statutorily authorized Early Intervention Teams in each Indiana county as a local planning group to develop and implement community based prevention and early intervention strategies that identify and assess children for needed services at age appropriate intervals and other appropriate times. The Family and Social Services Administration should provide the forum and infrastructure to determine the manner in which current funding for services can be maximized so as to expand and improve prevention and early intervention services. This strategy should promote: comprehensive (physical, nutrition and mental) care for the mother; child development information and education for parents; parenting support services to foster self-confidence and competence in parenting, on-going physical and mental healthcare for the mother and the newborn; developmental screens for children; risk assessments for families with children; aggressive enrollment of children into these needed services; implementation of an outreach plan that promotes access and utilization of these services; and maximization of federal reimbursements for Medicaid eligible services.

Target Population. Those who would be affected by the preventive service recommendations are pregnant women and children ages 0-5 years. Children ages 6 to 18 years would be most affected by early and on-going intervention services such as Early and Periodic Screening, Diagnosis and Treatment (EPSDT).

Policy Outcomes. Prevention and early intervention services promote beneficial well-being outcomes for children. These services are almost always less expensive than out-of-home placement and provide greater choice for parents and families to receive services in their own home environment and in the community. The utilization of re-directed funds from higher cost alternatives to support these services would reduce or possibly eliminate the need for additional appropriations. Moreover, the existence of such a policy would encourage the reduction of administrative costs, promote inter-agency collaboration and cooperation and endorse the establishment of standards and automated information systems that would improve efficiency.

System Barriers. Multiple state agencies administer similar programs but in very different ways, without sharing common points of entry, standards of service, funding streams or policy orientations. Strong administrative leadership with support from the Governor's Office will be required to ensure that the interests of all stakeholders are carefully balanced. State agency staff may be resistant to designing and implementing necessary changes. Multiple computer systems changes will be required. The affected population will need to be carefully monitored during periods of transition to ensure that services are not interrupted or adversely impacted through unintended consequences. New educational and training modules will need to be developed. Medicaid Waiver amendments to the federal government may be required to effectuate the changes, a third party evaluation must be initiated to ensure the changes meet the intended policy outcomes, and service delivery development must overcome the categorical program requirements of specific funding streams that result in "stovepipe" thinking.

Responsible Agency(ies) *and Action Steps:* The Governor should establish prevention and early intervention services as a necessary and critical component of a home and community-based service delivery system for children. The Indiana Family and Social Services Administration should be instructed to collaborate with the Indiana Department of Health, the Indiana Department of Correction, the Indiana Judicial Conference, the Indiana Judicial Center and the Indiana Department of Education to develop a common policy that promotes the Governor's policy on prevention and early intervention. Common points of entry are developed and implemented most effectively through common intake formats and processes. Common standards of service must be established and implemented after a consistent and holistic service and needs assessment is performed. A state and local partnership should endorse the expansion, access and utilization of First Steps, Healthy Families, Women, Infants and Children (WIC) Head Start, affordable and quality childcare and Hoosier Healthwise for all eligible families. Public information and outreach should make these services known to eligible families. The Indiana Family and Social Services Administration also should:

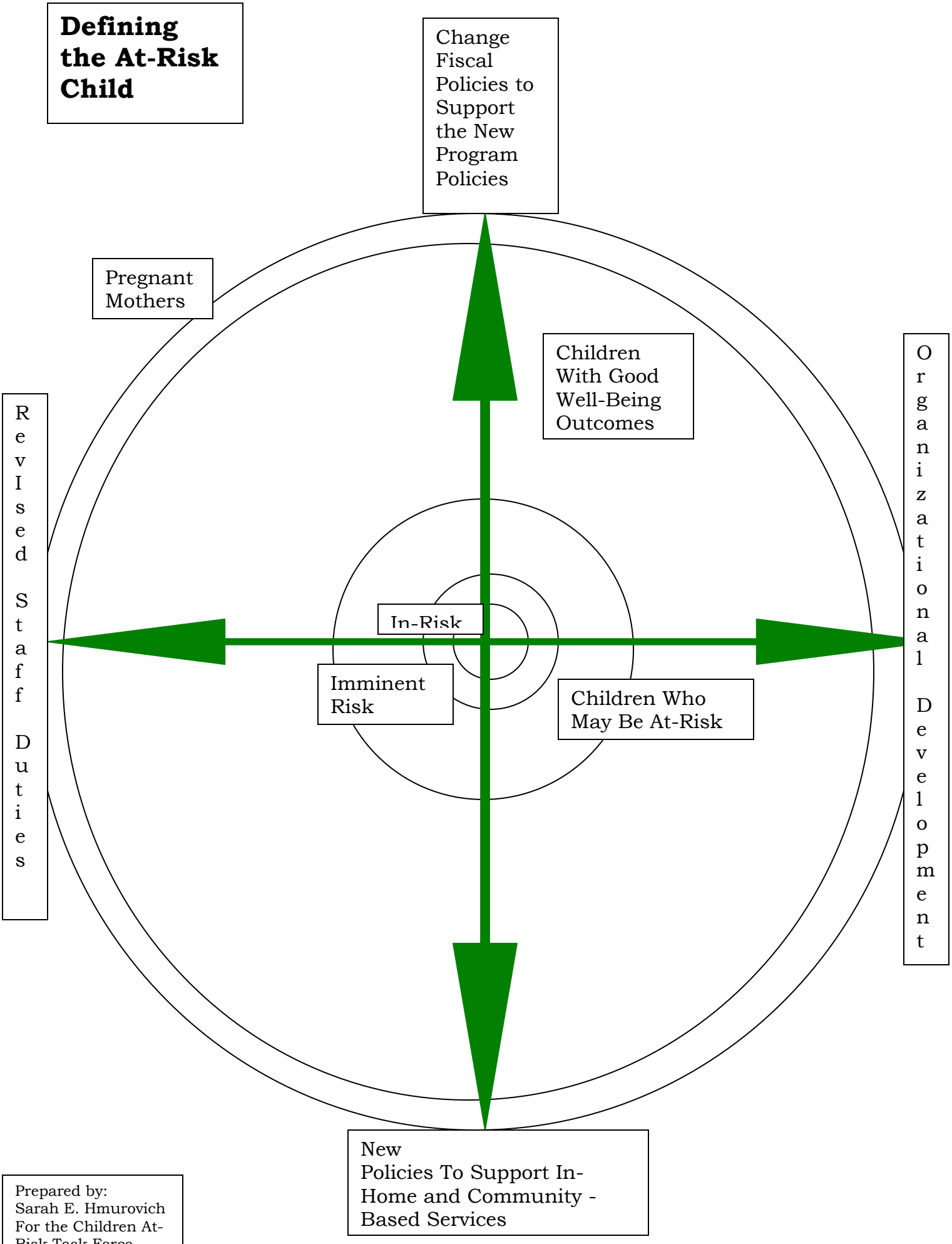
- Maximize the benefits available through the EPSDT component of Medicaid;
- Train all line workers and their supervisors on a holistic approach to prevention and early intervention services;
- Utilize the Early Intervention Team statute to serve as the initial community planning forum for the development and implementation of early identification and assessment of children, prevention and early intervention services;
- Collaborate with other state agencies both within and beyond the authority of the executive branch must be achieved that promotes the number one national education goal, that "children go to school ready to learn";
- Determine how funds from the Indiana Criminal Justice Institute, the Indiana Department of Correction, the Department of Health, local court systems, the Indiana Department of Education, and the Indiana Family and Social Services Administration can be maximized to serve children more effectively rather than by categorical funding stream requirements; and,
- Develop a monitoring system that tracks key indicators or benchmarks to measure the progress of this strategy commitment.

Fiscal Impact. This recommendation should be a component of the strategy to develop statewide access to unified systems of care for all children by June 30, 2007. In this manner, funds could be redirected to ensure that prevention and early intervention strategies can be implemented without jeopardizing current services and intervention for children at risk or currently in out of home placements. Additional appropriations from the federal government may be needed to expand

certain services, but expansion of these services and state share for these services can be managed within approved budgets by monitoring utilization and constant tracking of existing appropriations.

Targeted Completion Date: The re-direction of priorities to early identification and assessment and prevention and early intervention strategies should be completed by December 31, 2008.

Defining the At-Risk Child



Prepared by:
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Problem: Indiana uses multiple funding streams, including its CHOICE program, to provide services and supports to older Hoosiers and persons with disabilities who are at risk of losing their independence. Availability and funding for services is often inconsistent across programs even though the services needed are the same. Competition for individuals who provide these services also varies between some rural and urban areas.

Recommendation 1. Family and Social Services should develop a standardized, statewide rate ceiling for similar services provided. This should be implemented across all programs and reflect the actual cost of services being provided.

Target Population. Those persons with disabilities at risk of losing their independence or are living in more restrictive settings but are able and willing to live independently.

Policy Outcomes: Those persons with disabilities who want to remain or move to independent community-based homes will have the option to choose and privately employ their own attendant care workers and purchase those services from providers that support their unique choices and needs. Funding of this choice and availability of services will not be influenced by the enrollment in any particular program.

System Barriers: Potential need for increased funding. Administrative changes to reflect changes needed to implement new policy.

Responsible Agency(ies) and Action Steps: FSSA should examine and identify different program services reimbursements and develop a strategy to equalize payments across programs.

Fiscal Impact: Unknown until study done.

Targeted Completion Date: January 1, 2004

Problem: There are not enough individuals available who desire and are able to provide personal care attendant services and supports to consumers with disabilities who choose to direct their own care. This need for individuals is especially acute in rural areas. Once trained and experienced, it is even more difficult to retain their employment. This acute need is expected to increase in the near future.

Recommendation 2. FSSA should explore the option to provide benefits to increase the number of and retention of personal care workers. This evaluation should be based on the best practices of other states as well as the recommendations that were made in the Caregiver Commission Report.

Target Population. Individuals who live in the neighborhoods and communities of the persons needing these services. Young adults in high schools and technical schools. Persons employed in low wage jobs without health insurance or other benefits.
Policy Outcomes: There will be more individuals available for consumers to employ that will provide them services and supports in their own homes and communities. Individuals will stay on their jobs longer.

System Barriers: Funding of benefits

Responsible Agency(ies) and Action Steps: FSSA

Fiscal Impact: Unknown

Targeted Completion Date: Ongoing

Problem: Indiana does not have an enduring infrastructure to nurture and support consumer-directed personal assistance services.

Recommendation # 3. Family and Social Services must develop the infrastructure for consumer directed care. At a minimum, this infrastructure shall include:

- Policies and procedures to implement fiscal intermediary services to support consumer directed care that are standardized and available throughout Indiana including sufficient start-up money to ensure an adequate cash flow.
- An easily accessible single source of information and education for consumers and their employees, caseworkers and providers regarding how to implement and sustain the provision of consumer directed care
- A marketing plan that includes the publication of user friendly information regarding the availability of consumer directed services and the advantages and disadvantages of directing your own care.
- A standardized training curriculum for all case managers in the state providing services to consumers eligible for consumer directed care services and supports with training done with in six months of implementation of the program. Training and educational opportunities should be offered at least semi-annually.
- A menu of standardized training and educational options to support their decision to access consumer directed services and supports for all consumers and their employees. This should be done within 30 days of indicating an interest in the program.
- A statewide strategy, including the encouragement of public and private partnerships, for increased recruitment, retention and training of individuals willing to provide services and supports to persons with disabilities.

Target Population. Persons with disabilities who want to direct their own care in their own homes and in their own communities. Persons who are employed by or support the individual choices of consumers with disabilities.

Policy Outcomes: More consumers desiring and able to direct their own care in their own homes and communities.

System Barriers: Indiana policies and procedures that restrict or reduce the choices available to persons with disabilities.

Responsible Agency(ies) and Action Steps: FSSA; Implementation of the recommendations of the C-PASS Task Force.

Fiscal Impact: Administrative and consulting funds (state/federal and private) necessary to design and implement strategies that create the infrastructure.

Targeted Completion Date: January 1, 2004

Problem: Medicare and Medicaid beneficiaries have difficulty in obtaining approval for medically-necessary wheelchair and other durable medical equipment, assistive technology, and timely repair of existing equipment. There is generally no consideration for preventive care in the evaluation of medical necessity, which often leads to costly and painful health outcomes as well as potential limitations or loss of functional independence for the consumer. Written wheelchair and equipment policy generally appears to meet the needs of consumers but may not be implemented correctly or consistently by contracted, regional Medicare fiscal intermediaries or Indiana Medicaid's Fiscal Agent Contractor. Moreover, the consumer's needs are not well-evaluated and coordinated, which sometimes results in the purchase of expensive equipment that can not be used, returned, or replaced. Vendors are sometimes not monitored, and second opinions are not sought, both of which are especially critical since program policy imposes strict limits (time and quantity) on the acquisition of equipment for consumers. Because of these apparently process-related problems, consumers who are dependent upon wheelchair and other equipment and technology often suffer deteriorating health status, loss of employment and/or wages, and displacement from the community.

Recommendation 1: Medicare and Medicaid wheelchair and equipment coverage policy must be made more flexible to allow for a better evaluation of the consumers needs, consideration of preventive care, and better coordination of vendors.

Target Population. Those who would be affected by this change are Medicare and Medicaid-eligible adults who are frail and elderly and/or have physical or developmental disabilities and/or have mental illness.

Policy Outcomes. Implementation of this recommendation will significantly increase the consumer's productivity, morale, and quality of life. Since mobility is a basic activity of daily living, consumers who are dependent upon wheelchairs must have safe, reliable, and comfortable wheelchair equipment to allow them to function in the most independent manner possible. Reductions in approval time and processing requirements for wheelchair repair and replacement will positively impact the consumer's general health status, ability to secure and retain outside employment, and overall ability to function. Additionally, better coordination and evaluation of the consumer's needs will reduce and/or eliminate unnecessary expense that occurs when inappropriate equipment is purchased or when policy does not permit a less expensive, more appropriate option.

System Barriers. Since Medicare is a federal program that is operated by contracted, regional fiscal intermediaries, policies are not always consistently interpreted and applied. Similarly, the Indiana Medicaid Program relies upon a fiscal agent contractor to evaluate and authorize wheelchair and other equipment purchases. As a result, policy concerns expressed by consumers and government officials are not always properly routed and/or responded to, so policy change is very difficult to implement. In addition, consumer outreach is generally poor.

Responsible Agency(ies) and Action Steps. The Centers for Medicare and Medicaid Services (CMS) within the U.S. Department of Health and Human Services is responsible for implementing this policy change and/or reissuing wheelchair coverage policies to its Medicare fiscal intermediaries and consumers. The Office of Medicaid Policy and Planning within the Indiana Family and Social Services Administration is responsible for implementing this policy change within the Indiana Medicaid Program.

Action steps include:

- Review and evaluation of wheelchair coverage policies and processes administered by all Medicare fiscal intermediaries and the Indiana Medicaid Program.
- Determination of non-compliant Medicare fiscal intermediaries and policy/process problems within the Indiana Medicaid prior authorization process.
- Evaluation of wheelchair policy modifications necessary to provide preventive care and improve consumer service and health outcomes
- Determination of whether modification of regulations is necessary; drafting and promulgation of proposed regulatory changes
- Implementation of revised regulations, if necessary
- Implementation of policy and/or process changes
- Development of a consumer education protocol that will assist consumers in understanding coverage policies and changes as they occur

Fiscal Impact. The cost of implementing this recommendation is expected to be minimal, since it appears that Medicare and Medicaid wheelchair coverage policy already appears to meet the needs of consumers but is not being applied properly by the fiscal intermediaries or the Indiana Medicaid Program's fiscal agent contractor. There may, however, be some increase in administrative costs as consumer needs are more frequently evaluated.

Targeted Completion Date. This initiative should be pursued immediately with full resolution occurring by no later than July 1, 2004. If a change in regulation is required, than the proposed regulation should be published in the Federal Register by no later than December 1, 2003.

Problem: Individuals with mental illness who are admitted to a state hospital are dis-enrolled from the Indiana Medicaid Program during their period of hospitalization because of limitations within the State's computer systems. The systems-related difficulties occur because federal Medicaid regulation prohibits coverage of the hospital service, therefore states are responsible for paying the full costs. So, even though an individual does not lose his/her eligibility for Medicaid, his/her eligibility becomes temporarily "suspended" during the period of hospitalization in order to accommodate the shift in payment responsibility from Medicaid to the State. When this dis-enrollment from Medicaid occurs, individuals who are discharged from the state hospital into the community must wait an extended period of time for benefits to be re-instated. During that period, the individuals are denied vital pharmaceutical, treatment, and other health care services that are essential for successful transition (and sometimes even basic survival) into the community.

Unlike Medicaid, federal law requires an individual's eligibility for Social Security benefits to be discontinued[1] during the period of institutionalization in a state hospital. To ensure successful transition back into the community, federal law/regulation authorizes states to process the eligibility re-determination prior to the individual's discharge from the institution in order to ensure that benefits are available immediately upon the individual's discharge. Despite this federal authorization, however, Indiana does not have a mechanism/policy in place to re-determine eligibility prior to discharge so that it coincides with an individual's discharge. As a result, the individual is denied the monetary assistance (to which (s)he is entitled) that is absolutely essential for covering basic housing, food, and other expenses.

Recommendation 2: State eligibility policy and/or administrative process for Medicaid and Social Security benefits should be modified to ensure that there is no lapse in coverage when a consumer transitions from an institution into the community. There should also be developed an expedited process for persons who were not on Medicaid and/or who did not receive Social Security benefits at the time of admission to the state hospital to apply for and become approved for Medicaid and Social Security (when all eligibility requirements are met) prior to discharge in order to ensure that both Medicaid and Social Security benefits are available to the individual immediately upon discharge.

Target Population. Those who would be affected by this change are all adults age 18 to 64 with serious mental illness who are admitted to a state mental hospital and who are eligible for Indiana Medicaid and/or federal Social Security benefits.

Policy Outcomes. Implementation of this recommendation will provide a very fragile, at risk population (499 adults during SFY 2002[2]) with the basic supports needed to survive and eventually succeed in, the transition to the community. This policy change will significantly and positively impact health outcomes, as well as mortality rates among this population. In short, implementation of this policy recommendation restores or expedites eligibility for two programs to which many individuals are entitled, but does so in a timely manner.

[1] The Kaiser Commission on Medicaid and the Uninsured, Kaiser Commission on Medicaid and the Uninsured, "The Medicaid Resource Book", page 169.
[2] Indiana Division of Mental Health and Addiction Hospital DSS.

System Barriers. Since both Medicaid and the Social Security eligibility determination process are operated as joint federal/state programs that are administered according to each state's unique characteristics, laws, and regulations, program eligibility and administrative policies are not always consistently interpreted and applied among or even within states. Critical Medicaid and Social Security benefits that are not available during an inpatient hospital stay are often dropped during the hospital stay, either deliberately or unintentionally, making reinstatement of benefits unnecessarily burdensome and time-consuming. System changes may be required and may be complex to implement. Communication among state staff is poor, and care coordination for persons who are transitioning from an institutional back into the community is inadequate or non-existent. Previous housing arrangements may be lost, and may require extensive and time-consuming efforts to restore or identify new. Similarly, life-sustaining food and personal care items may not be accessible to consumers without the income received through the Social Security benefit. Consumers who depend upon essential drug and treatment protocols established prior to hospital discharge may experience serious and even life-threatening setbacks that reduce the likelihood of successful transition back to the community.

Responsible Agency(ies) and Action Steps. The Division of Mental Health and Addictions, the Division of Family and Children, the Office of Medicaid Policy and Planning, and the Disability Determination Bureau within the Indiana Family and Social Services Administration are responsible for evaluating and implementing this change.

Action steps include:

- Review and evaluation of existing policy.
- Determination of administrative and systems changes that are needed to implement the policy change.
- Development of an implementation plan with timelines.
- Training of state staff.
- Implementation of a real-time quality assurance protocol to verify reinstated coverage/intended outcomes prior to and immediately after hospital discharge.

Fiscal Impact. The administrative cost of implementing this recommendation is expected to be minimal. There can, however, be expected a significant cost savings to the State related to decreased lengths of stays and decreased incidences of re-institutionalization in state hospitals, which are as prescribed by federal law, paid with 100% state funds. Cost savings can also be expected by: providing preventive services that ameliorate the incidences of emergency room visits/acute care treatments; fewer and more efficient and effective case management services; and less expensive treatment and drug regimens that occur when consumer health status is stabilized.

Targeted Completion Date. This initiative should be pursued immediately with full resolution occurring by no later than October 1, 2003.

Problem: In order to participate in the Medicaid Program, State Medicaid Agencies are required to fund institutional care for its beneficiaries, while community-based funds are not required. Similarly, other state and federal public assistance programs establish criteria that limit funding in some way, often to the fiscal detriment of the State and the physical detriment of the consumer. The effect of these policies is to sustain a long-standing bias that favors institutional services over community-based services, even when the institutional services are more expensive and less desirable.

Recommendation 3: Funding for public assistance programs should be transparent to the consumer and should follow the consumer to the service setting of his/her choice. This principle has been embodied within Senate Enrolled Act 493 (2003 Indiana General Assembly).

Target Population. Those who would be affected by this change are all low-income persons who are eligible for and/or who receive public assistance.

Policy Outcomes. Implementation of this recommendation will allow for a greater number of Indiana's consumers to be served in cost-effective, community settings that reflect his/her choice in health care services. Providers will need to compete for consumers, thereby improving quality of care and consumer health outcomes. State program expenditures will need to be carefully monitored to ensure budgetary compliance. Resident census in institutional facilities (i.e. nursing facilities, intermediate care facilities for the mentally retarded/developmentally disabled) will decrease, while the acuity of the residents and the average facility reimbursement rates will increase. Similarly, the number of persons served in the community will increase, and it is likely that the acuity of those persons and the average cost of serving them in the community will also increase.

System Barriers. There will be a negative fiscal and economic impact on institutional providers, many of whom may appeal to the State and to the Legislature for relief. There may not be enough community-based services providers available to meet the needs of a growing consumer population. Quality assurance programs will need to be expanded in response to the growing shift of consumers away from institutional care and toward community-based care. Budget analysis and expenditure monitoring will be targeted to the expected and unanticipated effects of the policy change.

Responsible Agency(ies) and Action Steps. The Indiana Family and Social Services Administration and the State Budget Agency are responsible for implementing this policy change.

Action steps include:

- Review and evaluation of the administrative and funding limitations involved with the current fiscal administration of public assistance programs and this recommendation.
- Review and evaluation of the projected economic effects on the institutional and community-based providers.
- Development of an implementation plan.

Fiscal Impact. The cost of implementing this recommendation depends upon the approach taken by the State. If existing funding is maintained and capped, then there would be no fiscal impact to the public assistance programs to implement this change. In contrast, however, the negative fiscal and economic impact on institutional providers is likely to be dramatic since more

consumers are likely to choose community-based care if given the means to do so. If program funding is not capped or otherwise limited in some way, then there will be an undetermined increase in expenditures created by the addition into the public assistance system of new consumers (Woodwork Effect) who otherwise would have remained outside the system.

Targeted Completion Date. A comprehensive budgetary analysis should be developed by December 1, 2003. The change in administrative policy should occur on or before July 1, 2004.

Problem: Like most other states, Indiana is experiencing a severe economic downturn, creating extreme funding deficiencies. As a result, funding for social service/public assistance programs is being carefully scrutinized in order to determine how best and where to target cost containment initiatives, all of which are expected to adversely impact consumers and public assistance providers. In seeming contrast, recent court actions, such as *Olmstead v. L.C.,* mandate that states develop initiatives and expand opportunities to provide consumers with real choice in the care and type of services available to meet his/her needs. Clearly the objective is to shift the long-term care service delivery balance from traditional, institutional care to community-based care and allow consumers to age in place in the setting of his/her choice for as long as possible.

These two contrasting issues make it difficult for states to move forward with a long-term care vision. New initiatives that are anticipated to produce savings in the long-term, often require an initial funding investment that states are unable to afford in the current economic climate. As a result, long-term goals are compromised at the sake of short-term investments. Necessary policy and program changes, including some that are neither efficient nor effective, are delayed indefinitely.

Recommendation 4: The Indiana Family and Social Services Administration and other state agencies (i.e. the Department of Workforce Development, Housing, and the State Department of Health) should aggressively pursue all federal grant opportunities that will fund, in whole or in part, a shift in consumer services that will reflect consumer choice, independence, and quality of life and produce positive health outcomes and cost-effective policy initiatives.

Target Population. Those who would be affected by this change are all persons who are eligible for and receive public assistance.

Policy Outcomes. New federal grant initiatives are expected to assist states in shifting the delivery of critical health care and housing services to its low-income, frail, elderly and disabled populations. Provider industries will change in response to consumer demand.

System Barriers. Funding for federal grant initiatives may be limited in some way, requiring states to pick up a portion of the expense. This may be extremely difficult for states to do when experiencing severe budgetary constraints. Staffing new initiatives may also be difficult, when state staff is already dedicated to other projects and program initiatives. Time-consuming and costly computer system changes may be required.

Responsible Agency(ies) and Action Steps. The Indiana Family and Social Services Administration, the Department of Workforce Development, Housing, and the State Department of Health are responsible for researching, evaluating and pursuing all federal grant initiatives and opportunities.

Action steps include:
- Research of current and new federal grant initiatives.
- Evaluation of current and new federal grant initiatives current and new federal grant initiatives.
- Coordination with other agencies and stakeholders as necessary.
- Development of written grant applications.

- Timely submission of grant application.
- Administration of grant awards.

Fiscal Impact. The cost of implementing this recommendation depends upon the federal grant initiatives that are pursued. The state share will likely vary between no state investment, some/all administrative expense, and/or some/all service expense.

Targeted Completion Date. All grant opportunities should be researched and evaluated on a timely basis. Grant applications should be written and submitted on or prior to all published deadlines. Research of new and existing opportunities should be initiated immediately and should continue indefinitely.

Problem: State, federal, and local public assistance program policies that drive health care, housing, and other services are typically made with little or no consumer input. There is no formal mechanism, process, or consumer body that is regularly convened and relied upon to provide constructive input, education and guidance to policymakers. As a result, critical consumer programs and services are heavily influenced by provider issues and government concerns, limitations, and priorities, which may not address the needs, values and priorities of consumers.

Recommendation 5: The Indiana Family and Social Services Administration should create a cross-disability consumer advisory council to advise them and other state agencies on issues that facilitate continuing progress on Olmstead plan implementation and the movement of services toward home and community-based care.

Target Population. Those who would be affected by this recommendation include consumers and advocates who represent persons who are frail and elderly, persons with physical and developmental disabilities, persons with mental illness and/or substance abuse, and children and their families who are at risk.

Policy Outcomes. Implementation of this recommendation will improve state policymaking by incorporating consumer input earlier and more accurately, thereby reducing the need for system re-evaluation and re-design. State compliance with its Olmstead goals and priorities will be achieved quicker and more effectively. Consumers will be given more "voice" in the programs and services upon which they depend. State staff and providers will become more aware of and knowledgeable of consumer needs, issues, and concerns, thereby improving the quality and delivery of publicly-funded services.

System Barriers. State staff may be resistant to a consumer advisory process because of the number of stakeholder interests, boards and other groups with and to whom they already must consult and/or respond. Consumer representatives may have transportation and mobility limitations that may impede their participation.

Responsible Agency(ies) and Action Steps. The Indiana Family and Social Services Administration may establish this advisory council without administrative rule or state law. Action steps include:

- Appointment of members who represent all types of consumers in order to create a cross-disability forum
- Designation of a council chairperson and/or state staff who will support the activities of the council
- Identification of administrative resources that will fund the travel and meeting expenses of the members and the staff support
- Development of a meeting protocol and feed-back mechanism
- Identification of mission statement, goals and objectives

Fiscal Impact. The cost of implementing this recommendation will consist of administrative expense associated with dedicated state staff time and travel time and expense of council members.

Targeted Completion Date. The council members should be appointed by September 30, 2003, with the first meeting scheduled before December 1, 2003.